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Trauma Violence Abuse 2002; 3; 247

DOI: 10.1177/1524838002237329

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ADOLESCENT SEX OFFENDERS

A Review of the Literature

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Research over the past 20 years indicates that adolescent sex offenders account for a significant number of child sexual abuse perpetrators. Studies indicate that this group has a variety of severe family problems, including neglect and physical and sexual abuse. Academic and behavior problems, psychopathology, and social isolation tend to characterize adolescent sexual offenders. The research also indicates that juvenile sexual offenders are a heterogeneous population with diverse characteristics and treatment needs. A number of typologies have been developed to classify various types of offenders, but more empirical research is needed. Because of the diversity of the population, careful assessment is needed before treatment plans are developed and implemented. Most treatment programs have been modeled after treatment programs found to be effective with adult sex offenders, but new programs are aimed more specifically at juveniles. Based on the research, recommendations are made with respect to important target areas for treatment.

Key words: *adolescent sex offenders, correlates of adolescent sex offenders, assessment of sex offenders, treatment of sex offenders, delinquent sex offenses*

THE NATURE AND EXTENT OF JUVENILE SEX OFFENDING

Until the 1980s, juveniles who committed sex offenses received little attention in the research literature. Their behavior was often explained as normal experimentation or developmental curiosity, whereas the focus of investigation of deviant sexual behavior was on adult sexual offenders. However, crime reports and surveys have indicated that adolescents are responsible for about 20% of rapes and 30% to 50% of cases of child sexual abuse (Davis & Leitenberg, 1987; Deisher, Wenet, Papemy, Clark, & Fehrenbach, 1982; Groth & Lored, 1981).

Current estimates suggest that more than 70,000 boys and 110,000 girls are victims of adolescent perpetrators each year (Ryan & Lane, 1997). Such estimates may be conservative because of the reluctance to report adolescent offenders (Kemp-ton & Forehand, 1992). Over the past decade, the phenomenon of adolescents and children being the perpetrators against younger children has become increasingly recognized.

TRAUMA, VIOLENCE, & ABUSE, Vol. 3, No. 4, October 2002 247-260

DOI: 10.1177/152483802237329

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ingly recognized (Cashwell & Caruso, 1997; Straus, 1994).

These figures most likely underestimate the actual number of juvenile sexual offenders, because many of these incidents go unreported, and only a small number result in an arrest (Groth & Lored, 1981). Furthermore, studies of adult sexual offenders indicate that about half of adult offenders report that their first sexual offense occurred as a juvenile, and often their offenses escalated in frequency and severity over time (Becker & Abel, 1985). These findings have led to increased efforts to identify and treat juveniles who sexually abuse and to the recognition of this group as a distinct population for study (Bischof, Stith, & Wilson, 1992; Hunter & Becker, 1994; C. Veneziano, Veneziano, & Legrand, 2000).

The research literature indicates that juvenile sexual offenders are a heterogeneous population with diverse characteristics and treatment needs (Becker, Kaplan, & Tenke, 1992; Hunter & Becker, 1994; Hunter, Hazelwood, & Slesinger, 2000; Ryan & Lane, 1997; C. Veneziano et al., 2000). For example, although some juveniles may begin their behaviors with the onset of puberty, some begin at very young ages (Cantwell,

Generally, three groups of juvenile sex offenders can be identified: sexually assaultive juveniles, pedophilic juveniles whose victims were 3 or more years younger, and a mixed group that included juveniles who perpetrated more than one class of sex offense.

1988; Friedrich & Luecke, 1988; T. C. Johnson, 1988). They vary in terms of the ages of their victims and whether their offenses involve psychological coercion, violence, or both. Generally, three groups of juvenile sex offenders can be identified: sexually assaultive juveniles, pedophilic juveniles whose victims were 3 or more years younger, and a mixed group that included juveniles who perpetrated more than

one class of sex offense (Righthand & Welch, 2001).

Prior sexual victimization of sex offenders has been a consistent finding across both the adult and juvenile literature, despite considerable differences in sample selection and data

KEY POINTS OF THE RESEARCH REVIEW

Category

Findings

Extent/Nature of Perpetration/

Victimization

- Adolescent perpetrators represent a significant minority in rapes and child sex abuse cases
- More than half of adult sex offenders began perpetration as juveniles
- Perpetrators were often child sexual abuse victims themselves
- Victims usually young, more likely to be female, known to perpetrator

Characteristics of adolescent sex offenders

- Neglect and/or physical abuse
- Frequent separation from parents
- Sexually abused
- Severe trauma and familial dysfunction
- Lacking in social competence/social skills
- Disruptive school behaviors
- Truancy
- Academic difficulties
- Higher rates of learning disabilities and attention deficit disorders
- Poor verbal IQ
- About 25% have neuropsychological deficits, demonstrating poor impulse control and planning skills
- Recidivism for sex offending low, but higher for other delinquent offenses
- Characteristics overlap with delinquency in general

Typologies

- Offense-driven typologies: pedophilia, sexual assault, undifferentiated
- Behavior typologies have been developed but not empirically validated
- Other categorizations: sibling incest, female juvenile sex offenders, mentally retarded, very young sex offenders

Assessment

- Intellectual and neuropsychological
- Personality and psychopathological
- Social and behavioral
- Sexual
- History of victimization
- Substance abuse

Treatment

- Decreasing cognitive distortion
- Increasing empathy
- Enhancing problem-solving skills
- Decreasing deviant sexual arousal
- Enhancing social skills, including dating skills
- Dealing with trauma associated with being sexually victimized
- Management of emotions such as anger
- Relapse prevention a promising model
- Little research on treatment efficacy with this population

collection (Ford & Linney, 1995; Langevin, Wright, & Handy, 1989; Pierce & Pierce, 1987). In a national sample of adolescent sex offenders undergoing treatment (a database developed by the National Adolescent Perpetrator Network), nearly 40% of the adolescent sexual offenders were known to have been sexually abused before further disclosures or discoveries during treatment (Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996). A study of very young perpetrators suggested that at least 49% had been sexually abused (T. C. Johnson, 1988). Other studies have found even higher rates (50% to 80%) of sexual victimization (Friedrich & Luecke, 1988; Ryan, Lane, Davis, & Isaac, 1987). However, a recent meta-analysis did not find a relationship between prior sexual victimization and later recidivism in sex offenders (Hanson & Bussiere, 1998), although this study was of adult offenders. Widom's (2000) extensive research has indicated a variety of negative outcomes, including sexual perpetration, as a result of physical and sexual abuse and neglect.

In examining the relationship between juvenile sexual offending and prior victimization, several studies have examined the victimization behaviors and the characteristics of the victims of juvenile sexual offenders. In a national sample, Ryan et al. (1996) found that 35% had engaged in vaginal or anal penetration, 14.7% in oral-genital contact, and 17.9% in both types of contact; thus, about two thirds involved one or both of these behaviors. With respect to the gender of victims, a study reported in a national sample that twice as many victims were female than male (Ryan et al., 1996). Most other studies support these findings for juvenile sexual offenders, with females constituting approximately 70% of the victims (Worling, 1995b). However, it should be noted that when the victim was a child, the proportion of male victims increased, up to 63% (Davis & Leitenberg, 1987).

The literature indicates that adolescent males who commit child molestation offenses tend to have young victims (Davis & Leitenberg, 1987). The majority (more than 60%) of the victims were younger than 12, and two thirds of this percentage were younger than 6 (Fehrenbach, Smith, Monastersky, & Deisher, 1986). In a national sample, 63% were younger than 9, and the

modal age was 6 (Ryan et al., 1996). Adolescent male rapists, however, are more likely to select victims their own age or older.

Studies of relationships indicate that generally, adolescent sexual offenders know their victims (T. C. Johnson, 1988). One study found that in their sample, the victims were blood relations in 38.8% of the cases (Ryan et al., 1996), whereas in another sample of young perpetrators, about 46% involved family members (T. C. Johnson, 1988). A study comparing incest versus nonincest cases found that sibling offenders were more likely to have assaulted younger children than were nonsibling offenders (Worling, 1995a).

The relationship between early sexual victimization and later sexual offending is undoubtedly complex. The reasons for which some victimized youths later perpetrate and others do not have yet to be fully explored. Emerging developmental literature is focusing on the cognitive and psychophysiological effects of trauma on youths. Mechanisms that are thought to contribute to this cycle of abuse include a reenactment of the abuse (Longo, 1982; McCormack, Rokous, Hazelwood, & Burgess, 1992), an attempt to achieve mastery over resulting conflicts (Watkins & Bentovin, 1992), and the subsequent conditioning of sexual arousal to assaultive fantasies (Hunter & Becker, 1994). Rasmussen, Burton, and Christopherson (1992) argued that prior traumatization might be one of a number of precursors to sexual perpetration, with other predisposing factors including social inadequacy, lack of intimacy, and impulsiveness. The high incidence of child victimization might be the result of a reactive, conditioned, and/or learned behavior pattern, and a progression of sexual acts might reflect the reinforcing pattern in the development and perpetration of sexually abusive behaviors (Ryan et al., 1996).

The high incidence of child victimization might be the result of a reactive, conditioned, and/or learned behavior pattern, and a progression of sexual acts might reflect the reinforcing pattern in the development and perpetration of sexually abusive behaviors.

To assess individuals with deviant arousal, some researchers such as Weinrott (1996) have advocated and used direct measurement of sexual arousal through phallometric assessment (penile plethysmography). Research in this area suggests that sexual interests and sexual arousal of juveniles is less fixated than those of older adult offenders. Results reflect greater fluidity in the offense patterns of the juvenile offenders and generally less correspondence between measured arousal and offense histories than has been cited for adults (Hunter, Goodwin, & Becker, 1994; Kaemingk, Koselka, Becker, & Kaplan, 1995). The behavior of adolescent sex offenders might be more concerned with being abusive rather than about sexual deviance, with perhaps a minority of youths who commit sexual offenses that are more similar to that of adult offenders.

Although the samples are only partially comparable and studies differed in methods of data collection and analysis, the following characteristics of adolescent sexual offenders have been repeatedly described: a history of severe family problems; separation from parents and placement away from home; experience of sexual abuse, neglect, or physical abuse; social awkwardness or isolation; academic and behavioral problems at school; and psychopathology.

CHARACTERISTICS OF JUVENILE SEX OFFENDERS

Several studies that have described the backgrounds of juvenile male sexual offenders have found an overlap among adolescent sexual offenders, juvenile delinquents, boys from abusive and neglectful families, and socially isolated boys (Righthand & Welch, 2001). Although the samples are only partially comparable and studies differed in methods of data collection and analysis, the following characteristics of adolescent sexual offenders have been repeatedly described: a history of severe family problems; separation from parents and placement away from home; experience of sexual abuse,

neglect, or physical abuse; social awkwardness

or isolation; academic and behavioral problems at school; and psychopathology (L. Veneziano & Veneziano, in press).

Emerging research on juvenile sexual offenders suggests that they may be different from their adult counterparts in a number of ways (Hunter & Lexier, 1998). For example, early developmental trauma and familial dysfunction appear to be more common and severe in the histories of youths with sexual behavior problems than in those of adult sexual offenders (Hunter & Becker, 1994). Research indicates that trauma was often pervasive and chronic and occurred in the absence of environmental protections and supports (Hunter & Figueredo, 1999). Such histories are particularly seen in pre-pubescent sex offenders, who tend to display a variety of psychiatric, behavioral, social, and educational disturbances that appear to be related to their abuse histories, exposure to violence, and familial dysfunction (Caputo & Frick, 1999; Gray, Busconi, Houchens, & Pithers, 1997). Marshall, Hudson, and Hodgkinson (1993) argued that attachment problems, characterized by neglectful or rejecting parenting, lead to poor self-esteem, the inability to form attachments, and other influences that make youths susceptible to becoming sex offenders (Marshall & Mazzucco, 1995).

The percentage of juvenile sex offenders who experienced physical abuse as children ranges from 25% to 50% (Becker & Hunter, 1997). In addition, factors such as family instability, disorganization, and violence have been found to be frequent among youths who engage in sexually abusive behavior (Bagley & Shewchuk-Dann, 1991; Kobayashi, Sales, Becker, Figueredo, & Kaplan, 1995; Morenz & Becker, 1995). Studies have found that less than one third of juvenile sex offenders resided with both birth parents (Fehrenbach et al., 1986; Kahn & Chambers, 1991; Smith & Israel, 1987). Research on family communication styles has found that supportive communication and comments are limited in the families of both juvenile sex offenders and violent offenders, whereas negative communication, such as aggressive statements and interruptions, are frequent (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Not surprisingly, adequate support and supervision

appear to be lacking in the families of these juveniles (Hunter & Figueredo, 1999).

Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence (Knight & Prentky, 1993). Inadequate social skills, poor peer relationships, and social isolation are some of the difficulties identified in these juveniles (Fehrenach et al., 1986; Katz, 1990; Miner & Crimmins, 1995). The juveniles who had committed child molestation offenses were more socially maladjusted than other sex offenders or other delinquents and evidenced more social anxiety and fear of heterosexual interactions (Katz, 1990).

Juvenile sex offenders have been noted to have poor impulse control and poor judgment and problem-solving skills (Prentky, Harris, Frizell, & Righthand, 2000). They are thought to have less empathy for others and more difficulty recognizing and accurately identifying emotions in others (Knight & Prentsky, 1993). Cognitive distortions, such as blaming the victim, have been associated with increased rates of sexual reoffending among juveniles who committed sexual offenses (Kahn & Chambers, 1991; Ward, Hudson, & Marshall, 1995). "Hypermasculinity" has also been found as a characteristic of some juvenile offenders, particularly those who are verbally and physically coercive (G. M. Johnson & Knight, 2000; Prentky et al., 2000).

Juveniles who sexually offend typically have experienced difficulties in the school setting, including disruptive behavior, truancy, and/or a learning disability (Bourke & Donohue, 1996; Fehrenbach et al., 1986; Kahn & Chambers, 1991). Kahn and Chambers (1991) found that more than 50% of the juveniles in their study had behaved disruptively at school, 30% had been truant, and 39% had been diagnosed with a learning disability. In general, learning disabilities have been overrepresented among adolescent sex offenders (O'Callaghan, 1998). The incidence of attention deficit disorders in juveniles with sexual behavior problems has not been well established; studies indicate that 30% to 60% of juvenile sex offenders evidenced some symptoms of an attention deficit disorder

(Ferrara & McDonald, 1996; Kavoussi, Kaplan, & Becker, 1988).

Studies have indicated that juvenile sex offenders' average IQ scores tend to be in the low average range, similar to that of other groups of delinquents (Ferrara & McDonald, 1996; Jacobs, Kennedy, & Meyer, 1997; Spaccarelli, Bowden, Coatsworth, & Kim, 1997). They tended to score more poorly on verbal subtests, which is a finding that tends to hold true for delinquents in general. Juvenile sex offenders with lower IQ scores showed significantly more inappropriate sexual behaviors than did those with higher scores (McCurry et al., 1998).

A few studies have investigated possible neuropsychological deficits in juvenile sex offenders and comparison groups of non-sex offenders. Neuropsychological impairments were found at higher rates in groups of juvenile sex offenders and juvenile violent non-sex offenders. Ferrara and McDonald (1996) noted that the research literature indicates that juvenile delinquents have demonstrated two areas of impairment—difficulties with executive functions (planning skills and impulse control) and deficits with respect to verbal skills—and that between one fourth and one third of samples demonstrate some degree of neuropsychological impairment. It appears that deficits in verbal cognitive functioning, which can be seen indirectly in higher rates of impulsivity and poor judgment, might contribute to inappropriate sexual and other delinquent behaviors among juveniles.

Overall, juveniles who commit sex offenses and juveniles who commit other types of offenses share many characteristics. That is, they tend to come from dysfunctional families, and they are more likely to have been abused and to have received inadequate support and supervision. Both groups tend to have poor verbal skills, more behavioral problems at school, lower academic achievement, and higher rates of learning disabilities. They tend to have

It appears that deficits in verbal cognitive functioning, which can be seen indirectly in higher rates of impulsivity and poor judgment, might contribute to inappropriate sexual and other delinquent behaviors among juveniles.

poorer social skills and perhaps have higher rates of neuropsychological difficulties, particularly related to planning and impulse control.

Follow-up studies of juvenile sex offenders have indicated that, overall, recidivism rates hover around 50% and consist of both sexual and nonsexual offenses. A 50% recidivism rate is comparable to the recidivism rate of adult and juvenile offenders in general (Siegel, 2001). Recidivism in terms of sexual offenses is not particularly high. For example, recidivism rates for sexual offenses have ranged from 8% to greater than 30%, with most studies indicating ranges from 10% to 15% (Righthand & Welch, 2001). Recidivism rates reflecting nonsexual offenses are higher, ranging from 16% (Sipe, Jensen, & Everett, 1998) to 54% (Rasmussen, 1999). Worling (2001) found that more pathological subgroups were most likely to be charged with a subsequent violent (sexual or nonsexual) or nonviolent offense. A meta-analysis of sex offender treatment programs indicates that age of the offender and type of treatment affect outcomes (Alexander, 1999).

These findings suggest that when a longitudinal perspective is used, sexual offending among juveniles is often part of a pattern of general delinquency. The data concerning recidivism indicate that juveniles who commit sexual offenses are more at risk for subsequent nonsexual delinquency than sexual recidivism and are more like other juvenile delinquents rather than adult sex offenders. The research concerning sexual arousal of adolescent sex offenders that indicates that their sexual interests and arousal are less fixated and more fluid would appear to support this conclusion.

TYOLOGIES OF JUVENILE SEX OFFENDERS

As stated previously, the general consensus among researchers is that juveniles who have committed sex offenses are a heterogeneous group. Consequently, for both theoretical and practical reasons, there is a need to develop reliable and valid typologies. Unfortunately, the typologies developed to date have largely been intuitively derived, and they have not been adequately empirically validated. Some typologies

have been offense driven (e.g., rapists, child molesters, etc.), whereas others have been personality driven (e.g., disturbed impulsive, pseudosocialized, etc.).

An example of an offense-driven typology can be seen in the classification developed by Graves, Openshaw, Ascione, and Erickson (1996). This classification consisted of three categories: pedophilic, sexual assaultive, and undifferentiated. Pedophilic juveniles tended to lack social competence and to be socially isolated; they molested children, usually girls, at least 3 years younger than themselves. The sexual assaultive group typically assaulted peers or older females. The undifferentiated group committed a variety of offenses, and the ages of their victims varied considerably.

O'Brien and Bera (1986) developed a seven-category classification scheme for juvenile sex offenders, used by many residential facilities. These categories include (a) naive experimenters, (b) undersocialized child exploiters, (c) sexual aggressives, (d) sexual compulsives, (e) disturbed impulsives, (f) group influenced, and (g) pseudosocialized. Although these categories appear to have face validity, there has not been systematic investigation of their reliability and validity.

Other studies have made distinctions based on other characteristics. For example, a few researchers have examined sibling incest (Araji, 1997; O'Brien, 1991), although it would appear that they are a heterogeneous group (Righthand & Welch, 2001). Generally, females are classified and studied separately from males or are compared to them (Bumby & Bumby, 1997; Ray & English, 1995). Juvenile sex offenders with mental retardation have also been the focus of research as a separate group (Gilby, Wolf, & Goldberg, 1989). Hunter et al. (2000) have found differences empirically between male juveniles arrested for sex offenses against children versus those who victimized peers or adults. Attention has also been concentrated on young children who committed sex offenses (Araji, 1997; Gries, Goh, & Cavanaugh, 1996; Ryan, 1999). Significant differences have been found between younger perpetrators (ages 6 to 9) and older children ages 10 to 12 (Gray, et al., 1997).

The most promising empirically derived typologies are still in the process of development. Prentky et al. (2000) have developed a protocol for risk assessment, the Juvenile Sex Offender Assessment Protocol, and noted the problems associated with evaluating risk in this population. Kaufman et al. (1998) focused on the pattern of behaviors that perpetrators display in the periods leading to and following sexual contact, the *modus operandi*. Subgroups of offenders differed significantly in the strategies used (Kaufman et al., 1998).

Finally, Worling (2001) used the California Psychological Inventory to establish groups. Cluster analysis revealed four personality-based subgroups: antisocial/impulsive, unusual/isolated, overcontrolled/reserved, and confident/aggressive. Significant differences were observed in his initial study with respect to variables such as physical parental marital status, residence, and disposition of their cases.

Progress in the field will be significantly enhanced once reliable and empirically validated typologies emerge. Typologies based on combining type of offense with individual personality characteristics would appear to hold the most promise. The use of multivariate statistical techniques and hierarchical cluster analysis is likely to prove to be beneficial in this regard.

ASSESSMENT OF JUVENILE SEX OFFENDERS FOR TREATMENT

Because of the heterogeneous nature of juveniles who have committed sex offenses, it is generally conceded that a comprehensive clinical assessment be performed on each offender prior to the development and implementation of an individualized treatment plan. Such a comprehensive clinical assessment should, at a minimum, identify strengths and weaknesses in the following six areas: (a) intellectual and neuropsychological, (b) personality and psychopathological, (c) social and behavioral, (d) sexual, (e) history of victimization, and (f) substance usage (Kraemer, Spielman, & Salisbury, 1995).

A thorough intellectual assessment is necessary for at least two reasons. First, cognitive-behavioral techniques need to be modified

when used with juveniles with less than average intelligence. Second, studies have empirically demonstrated a relationship between lower intelligence, poorer academic performance, truancy, and recidivism among juveniles who commit sex offenses (Ferrara & McDonald, 1996; McCurry et al., 1998). Because some studies maintain that as many as a third of juvenile sex offenders have some indication of a neuropsychological deficit (Ferrara & McDonald, 1996), it seems prudent to routinely include some form of neurological and/or neuropsychological screening as part of a comprehensive clinical assessment.

The potential comorbidity of sexual offending and various forms of psychopathology also warrants the inclusion of assessment techniques designed to detect the presence of an accompanying psychopathological condition. Needless to say, any such condition identified would need to be treated as well. As a group, juveniles who commit sex offenses are quite likely to be deficient in a variety of social skills, so a thorough assessment of these deficits will aid in the development of an individualized treatment plan. Because the commission of a sexual offense is what brought the juvenile to the attention of treatment personnel, a truly individualized treatment plan cannot be developed without an extensive investigation of the offender's sexual history (Bengis, 1997; Saunders & Awad, 1988).

As stated previously, studies indicate that significant proportions of juveniles who commit sex offenses have been the victims of emotional, physical, and/or sexual abuse (Ryan et al., 1996; C. Veneziano et al., 2000). Before the traumatic consequences of such experiences can even hope to be resolved, their nature and extent must be thoroughly investigated. Finally, it is important to assess whether the juvenile has a substance abuse problem, because from a

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psychopharmacological standpoint, most psychoactive substances have a disinhibiting effect that might contribute to future reoffending (Becker & Hunter, 1997).

Recent research focuses on risk and protective factors. The Clinical Assessment Package for Assessing Client Risks and Strengths, for example, is a newly developed set of instruments that gives equal consideration to client strengths and weaknesses, yielding a risk score and an asset score. This information may be useful for assessment intervention and the evaluation of the effects of treatment (Gilgun, 1999; Gilgun, Keskinen, Marti, & Rice, 1999).

Three other assessment issues have been raised in the research literature on juveniles who commit sex offenses. The first issue is whether lie detectors should be used in an attempt to enhance the veracity of an offender's statements regarding his or her sexual offending behaviors; due to the inherent questionable reliability of lie detectors at the present time, the general consensus in the research community is that they should not routinely be used (Bourke & Donohue, 1996; Cellini, 1995). The second issue is whether phallometric assessment should be used to assess deviant sexual arousal; because of the ethical problems associated with the use of phallometric assessment, the general consensus is that its use should not be routinely employed. The third issue is the need to obtain information from multiple sources, including self-reports, interviews, psychological tests, interviews with family members and victims, and

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official records (Bonner, Marx, Thompson, & Michaelson, 1998; Hunter et al., 2000; National Adolescent Perpetrator Network, 1993). It should also be noted that several research studies have concluded that labeling juveniles as sex offenders has potentially negative consequences and should be avoided (Hunter et al., 2000; National Adolescent Perpetrator Network, 1993; Ryan & Lane, 1997). This is particularly the case because it appears that juveniles

are at lower risk for sexual recidivism and more malleable to change than is believed to be the case for adult offenders.

TREATMENT OF ADOLESCENT SEXUAL OFFENDERS

Because of the nature of their offenses, the treatment of juvenile sex offenders must address both the needs of the individual and the needs of the community. Although it has been argued that a continuum of treatment models using the concept of the least intrusive setting should be developed, most treatment programs for juveniles who have committed sex offenses were long-term (12 to 24 months), specialized residential programs. Thus, the need to protect the community from further offending usually took precedence over the needs of the individual (National Adolescent Perpetrator Network, 1993). More recently, however, the majority of juvenile sex offenders are being treated in the community (Hunter et al., 2000; Lee & Olender, 1992; Ryan & Lane, 1997; Worling & Curwen, 2000).

To date, little research has been conducted that conclusively demonstrates the effectiveness of particular treatment programs or specific treatment interventions for juveniles who have committed sex offenses. Traditionally, treatment programs were modeled after treatment programs used with adult sex offenders, but it has not been established whether such programs are in fact effective with juveniles (Marshall & Barbée, 1990).

At the present time, many treatment programs for juveniles who have committed sex offenses use cognitive-behavioral techniques conducted in groups. Target areas for treatment typically include the following: (a) decreasing cognitive distortions; (b) increasing empathy; (c) enhancing problem-solving skills; (d) decreasing deviant sexual arousal; (e) enhancing age-appropriate social skills, including dating skills; (f) resolving traumatic consequences associated with being victimized; and (g) enhancing management of emotions, such as anger (Becker & Hunter, 1997; Hunter & Figueredo, 1999; National Adolescent Perpetrator Network, 1993).

However, at this point in time, there is considerable ongoing research evaluating program models for juveniles. Such programs are more holistic and comprehensive than earlier models. Newer programs are being influenced by the research on delinquency, psychiatric disorders, and the research on risk and asset models (Borduin, 1999; Marshall, 1996; Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998). The applications of risk and protective factors have led researchers to recommend continuous reassessments of juveniles for both strengths and risks to keep pace with the changes occurring in adolescence (Gilgun, 1999; Gilgun et al., 1999; Ryan, 1999). These juvenile programs differ from those of adults, because the research now indicates that juveniles are more changeable than adults and more at risk in terms of global functioning than adults and at lower risk for sexual recidivism than was initially assumed (Prentky et al., 2000; Worling & Curwen, 2000).

Some researchers have argued that programs designed to focus only on sex-offending behavior are limited and that, given the other problems many juvenile sex offenders also experience, a more holistic approach is needed. Thus, treatment should include strategies to enhance impulse control and good judgment (Becker & Hunter, 1997). Family interventions and the facilitation of positive school attachments are recommended as treatment goals (Miner & Crimmins, 1995). Because truancy is empirically correlated to juvenile recidivism (Jenkins, 1997; Gottfredson, 2000), treatment should target school performance. Bourke and Donohue (1996) emphasized the development of dating skills as a treatment component.

Perhaps the most promising holistic approach is multisystemic therapy (MST), a flexible and individualized treatment approach that addresses the multiple determinants of antisocial behavior in the youth's natural ecology. The youth's family, school, work, peers, and neighborhoods are viewed as interconnected systems with reciprocal influences, and all are addressed in MST (Borduin, Henggeler, Blaske, & Stein, 1990; Henggeler, Cunningham, Pickrel, & Schoenwald, 1996; Swenson et al., 1998). More assessment and intervention in the social con-

texts of these youths is involved, as opposed to the traditional therapies used with adults. This technique has demonstrated long-term reduction in criminal activity and violence in high-risk violent youths (Borduin, 1999; Henggeler et al., 1996). MST was found to be more effective than individual therapy in improving important family and peer correlates of antisocial behavior and in preventing future criminal behavior (Borduin, Mann, Cone, & Henggeler, 1995). Recent research indicates promise for MST with young sexual offenders (Borduin, 1999; Swenson et al., 1998).

A particularly problematic issue in the treatment of juveniles who have committed sex offenses is the selection of an intervention designed to decrease deviant sexual arousal (National Adolescent Perpetrator Network, 1993). Numerous researchers have raised ethical concerns related to the use of aversive conditioning techniques involving electric shock and noxious chemicals (Becker & Kaplan, 1993; Freeman-Longo, Bird, Stevenson, & Fiske, 1994). Masturbatory satiation techniques are controversial and hard to administer in a controlled fashion with juveniles, but masturbatory conditioning (pairing masturbation with nonproblematic fantasy) and covert sensitization (which pairs aversive consequences with problematic thoughts) are widely used (Becker & Hunter, 1997; Hunter & Becker, 1994; Hunter & Lexier, 1998).

The effectiveness of covert sensitization and masturbatory conditioning with juveniles has not been adequately empirically demonstrated. A promising intervention is vicarious sensitization, in which juveniles are exposed to a taped crime scenario designed to stimulate arousal and then immediately afterward, they view an aversive video that presents the negative social, emotional, and legal consequences of sexually abusive behavior (Weinrott, Riggan, & Frothingham, 1997). However, the effectiveness

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of vicarious sensitization needs to be empirically established (Hunter & Lexier, 1998). Furthermore, advocates of MST argue that enhancing competencies, ecological supports, and normalizing experiences is more relevant than decreasing deviant arousal, which their research suggests is less often the source of the sexual offending behavior (Borduin, 1999; Williamson, Borduin, & Howe, 1991).

Most treatment programs also incorporate a relapse-prevention component. Relapse prevention was initially designed to help substance abusers deal with and prevent the recurrence of drug abuse. When used with juveniles, this program requires that the adolescents learn to identify factors associated with an increased risk of sex offending and use strategies to avoid high-risk situations or effectively manage them when they occur. For example, if a youth's offending behavior occurred while baby-sitting, it would seem prudent for him to avoid such jobs. When relapse prevention is applied to children

Programs that target the specific problems of the individual offender would seem more likely to be effective, rather than attempting to apply "canned" programs to all juvenile offenders who have been found to have committed sexual abuse.

and adolescents, greater emphasis is placed on external supervision to prevent further problems. For example, if baby-sitting is a problem, parents should not require the juvenile to baby-sit

or allow him to be in high-risk situations where the temptations are greater (Gray et al., 1997).

The incorporation of a relapse-prevention component to the treatment protocol for adolescent sex offenders appears to be promising conceptually. Although theoretically sound, empirical studies investigating the effectiveness of using this approach with juveniles who have committed sex offenses have yet to be conducted (Gray & Pithers, 1993).

Noting the similarities between juveniles who commit general delinquent, nonsexual acts and juveniles who commit sex offenses, several researchers have argued that relevant empiri-

cally based treatment interventions for juvenile delinquents be used with those who commit sex offenses, whenever the interventions appear to be indicated. Izzo and Ross (1990) argued that programs based on cognitive therapy were effective. Multisystemic therapy, applied to violent offenders, appears to have considerable promise for sexual offenders (Borduin, 1999; Borduin et al., 1995; Lipsey & Wilson, 1998).

CONCLUSIONS

The Key Points of the Research Review summarize the current research, and below is a list of implications of this research. The research literature indicates that juveniles who have committed sex offenses are a heterogeneous group who are likely to have a number of special needs related to their families, schools, and social competencies in addition to the special risks posed by their sexually abusive behaviors toward others. There are currently no validated classifications of juvenile adolescent offenders, although some efforts at differentiating subtypes have taken place.

Juvenile sexual offenders should be assessed in a variety of areas, given the findings of the research, so that appropriate treatment plan may be established. Programs that target the specific problems of the individual offender would seem more likely to be effective, rather than attempting to apply "canned" programs to all juvenile offenders who have been found to have committed sexual abuse.

Cognitive-behavioral techniques and multisystemic therapy have been the most promising techniques used with juvenile delinquents. Given that juvenile sexual offenders share many of their characteristics with other delinquents, research should perhaps focus on these programs found to be effective with delinquents in addition to programs that have been used with adult sex offenders. Relapse prevention approaches would also appear logically to be techniques that might prove to be effective with juvenile sexual offenders. Further research into classification, assessment, and treatment of this population is much needed.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

Category

Implications

- Nature/extent of perpetration/victimization
- Importance of breaking the cycle: Many perpetrators were abused; some adult offenders began sexual offending in adolescence.

Characteristics of adolescent sex offenders

- Adolescent sexual offenders will need a variety of assistance, including dealing with family pathology, school difficulties, social skills, and impulse control.
- Typologies
- There is a need for empirical testing of classification schemes.

Assessment

- Adolescent sexual offenders are a heterogeneous group and will require individual assessment to identify specific skill deficits and difficulties, which must be matched to treatment efforts.

Treatment

- Because adolescent sexual offenders have much in common with delinquents, successful programs with that population might be applied to this group.
- Cognitive strategies and the relapse prevention models appear promising.
- There is a need for research on treatment efficacy.

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SUGGESTED FUTURE READINGS

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